FLWEMS Paramedics Adult Protocol for the Management of:
OBSTETRIC EMERGENCIES

Summary of Changes
Changes to this protocol are made in an effort to assure patient safety for both the mother and newborn during a pre-hospital emergency childbirth and transport to the medical treatment facility. Changes to this protocol include:

- *If pre-hospital emergency delivery is immanent, contact dispatch and have an ALS ambulance (when available) respond to the scene with the TI 500 Transport Incubator*
- *When possible, newborns should be transported to the hospital by a secondary responding ambulance properly secured within the TI 500 Transport Incubator.*

Indications
To outline the paramedic care and management of patients experiencing complications of pregnancy.

General Care

1. Establish an airway as outlined in FLWEMS Paramedics Adult Protocol for the Management of Airway & Ventilation and administer supplemental **Oxygen** as needed.

2. Position patient on her left side.

3. Obtain baseline fetal monitor strip at referring facility (if applicable) and fax to receiving facility. Contact medical control prior to transport for suspected fetal compromise. (Applies to facility-to-facility patient transfers only).

4. Establish an IV of **0.9% NaCL** or **Lactated Ringers**.

5. Monitor fetal heart rate every fifteen minutes en route.

6. Document results of most recent cervical status check (if applicable) to include:

   a. Integrity of Amniotic.

   b. Vaginal discharge i.e. blood, amniotic fluid, and meconium stain.

7. Monitor and document frequency, duration, and intensity of contractions if any.

8. Transport to appropriate Emergency Department.

9. Contact medical control for further orders as needed.

Pre-Term Labor

1. IV fluid based on hydration status and urinary output. Goal is to keep patient euvolemic with urine output of 35-50mLs/hr.

2. Administer **Terbutaline Sulfate** (Brethine) 0.25mg SQ every 20 minutes x3 PRN for contractions.

   a. Monitor for tachycardia, **HOLD** if HR >120 **OR** if patient is receiving **Magnesium Sulfate** infusion.

3. Contact medical control prior to the administration of **Magnesium Sulfate** 4-6Gm IV bolus over 20 minutes followed by a **Magnesium Sulfate** infusion of 2-3gms/hr.

4. Contact medical control if further tocolysis is needed.

5. Cervical exam is best done by a physician utilizing a sterile speculum. Examine cervix only if at a scene and patient is in active labor.

Pre-Eclampsia
(Hypertension, edema, and proteinuria)

1. Assess patient for neurologic changes including deep tendon reflexes, visual disturbances, nausea, and headache. Also assess peripheral edema, respiratory distress, and urinary output.

2. Protect patient from excessive stimulation and institute seizure precautions.

3. Establish IV of **0.9% NaCL** or **Lactated Ringers** at 125cc/hr.

4. Contact medical control prior to the administration of **Magnesium Sulfate** 4-6 Gm IV bolus over 20 minutes followed by a **Magnesium Sulfate** infusion of 2-3gms/hr.

   a. Stop **Magnesium Sulfate** drip if any signs of magnesium toxicity develop to include:

      (1) SBP ≤90mm/Hg

      (2) Patient develops dyspnea

      (3) Mental status changes

      (4) Negative patella reflexes

5. Contact medical control if further blood pressure control is required.

Eclampsia
(Pre-eclampsia with seizure)

1. Establish an airway per Airway and Ventilation Protocol utilizing RSI protocol if indicated.

2. During seizure, prevent aspiration and protect from seizure induced injuries.

3. Contact medical control prior to the administration of **Magnesium Sulfate** 4-6 Gm IV bolus over 20 minutes followed by a **Magnesium Sulfate** infusion of 2-3gms/hr.

4. For seizure control may administer **Diazepam** (Valium) 2-10mg IVP.

5. Notify medical control with the onset of eclampsia.

Emergency Delivery

1. Alert receiving facility.

2. If pre-hospital emergency delivery is immanent, contact dispatch and have a second ALS ambulance *(when available)* respond to the scene with the TI 500 Transport Incubator.

3. Prepare for birth by positioning mother and gathering supplies i.e. emergency OB kit with bulb syringe, extra towels and blankets.

4. If Amniotic intact, do not rupture as they may provide a cushion for the baby.

5. During a vertex delivery gently apply pressure on the presenting part to prevent rapid expulsion. After the head is delivered, assess for a nuchal cord, if cord is around neck attempt to slip it over the head and off the neck. If too tight, clamp in two places and cut in the middle. Then suction the mouth

first and then the nose. To continue delivery, place palms on both sides of infant's head and apply gentle downward traction. Once the anterior shoulder is delivered, apply the traction upward to deliver the posterior shoulder.

6. During a breech delivery allow infant to deliver to the waist without active assistance, supporting the lower body only. Once the legs and buttocks are delivered, delivery of the head can be assisted by inserting two gloved fingers into the vagina and placing them on the cheek-bones on either side of the infant's nose thereby creating an airway. Place gentle downward pressure on the cheek-bones attempting to bring the chin to the chest *(delivery may then occur spontaneously)*. If head still not delivered, maintain the best airway possible in this manner and alert the receiving facility.

Immediately After Deliver

1. Suction mouth and nose again.

2. Clamp umbilical cord 3-4 inches from abdomen. Keep infant at level of uterus until cord is clamped.

3. Institute neonatal resuscitation techniques as described in NALS Protocols.

4. Utilize methods to maintain infant body temperature:

   a. Skin to skin if possible

   b. Dry blankets & ambulance heater

7. Allow placenta to deliver spontaneously without any pressure on cord.

8. Control bleeding after placenta is delivered by fundal massage.

9. Contact Medical Control to administer **Oxytocin** *(Pitocin)* 20mg in 1000mls of warm LR titrated to control uterine bleeding.

10. If bleeding persists implement Obstetric Hemorrhage protocol.

11. Mother should be transported to the hospital by the initial responding ambulance properly secured on the adult cot.

12. The newborn should be transported to the hospital by the secondary responding ambulance properly secured within the TI 500 Transport Incubator *(when available).*

Special Considerations

1. In the case of a prolapsed cord, place the mother in a shock position with her hips elevated, insert a gloved hand into the vagina and gently push the baby's head off the cord. Transport the patient maintaining this position. Do not remove hand until relieved by receiving hospital personnel.

2. Multiple births are unusual but a possible occurrence. Be aware of the possibility and be attentive to the mother after first delivery.

3. When possible, newborns should be transported to the hospital by a secondary responding ambulance properly secured within the TI 500 Transport Incubator.

CAIRA/Chemical Surety Considerations
None

Triage Considerations
Refer to S.T.A.R.T. Triage Protocol

END OF SOP – NOTHING FOLLOWS